State of Rhode Island and Providence Plantations
Governor's Council on Behavioral Health
Richard LeClerc, Chair

EMERGING POPULATIONS IN RHODE ISLAND'S BEHAVIORAL HEALTH SYSTEM

Subcommittee on Emerging Populations
Nicki Sahlin, Ph. D., Chair
Elizabeth Earls, Co-Chair

Final Report November 9, 2004

Subcommittee Members:

Nicki Sahlin, Ph.D., Chair, NAMI RI
Elizabeth Earls, Co-chair, RI Council of Community Mental Health Centers
Paul Block, Ph.D.
Linda Bryan, member of Council
Neil Corkery, Drug and Alcohol Treatment Association of RI
Bob Crossley, Gateway Healthcare, Inc.
Sandra DelSesto, Initiatives for Human Development
Mary Dwyer, NRI Community Services
The Hon. Stephen P. Erickson, District Court, State of Rhode Island
Frederick Friedman Ed.D., RI Department of Corrections
Jim Thomas, Riverwood Mental Health

Staff Support, Division of Behavioral Health
Katherine Lyon, Ph.D., Associate Director
Jim McNulty, Principal writer
Janet Spinelli
Richard Sabo
Noelle Wood, Principal data analyst

Executive Summary:

Early in 2002, Executive Director of the Division of Behavioral Healthcare, Craig Stenning, requested that the Governor's Council appoint a subcommittee to consider what underlay the 100% increase in state funded acute psychiatric hospitalizations from Fiscal Year 1996 through FY 2001. The acute psychiatric hospitalizations ended up being a 167% increase through the end of FY 2003.

The most common hypothesis was that this was a group of younger, character-disordered individuals, not well known to the traditional mental health system. This was reflected in the charge to the subcommittee, approved by the Governor's Council. The picture of patients was far more complicated, since there were increases in all age cohorts, the greatest being in the 18-25 year old and 31 to 40 year old cohorts. Substance was a factor in about half the admissions, and mood disorders were the most common disorders. Individuals were largely (< 30%) unknown to the CMHOs prior to hospitalization.

There were no answers internal to the system that answered the question as to why the increase; for that the subcommittee turned to analysis of the effects of 2 events, both occurring in 1999: the approximately 20% rate cut by Blue Cross of Rhode Island, and the failure and closing of Harvard-Pilgrim in Rhode Island.

These events devastated the private outpatient system, and have greatly reduced the number of outpatient mental health providers who accept private insurance. This has led to the displacement of many patients from the private to the public sectors, since access to providers has been reduced.

The subcommittee is making six recommendations for action to the Council, including, among other items, a letter to Blue Cross and United Health that they consider an immediate minimum 20% rate hike for outpatient providers. The subcommittee also recommends an increase in funding for GOP services, better treatment for co-occurring disorders, a closer working relationship with the Coalition on Homelessness, especially in data analysis, and that the Division determine the feasibility of a study on how to best intervene appropriately with the group of individuals identified as high users of system resources in this report.

Several steps have been taken by the Division in response to interim reports of this committee, and are appended to this report. Data analyses are available upon request.

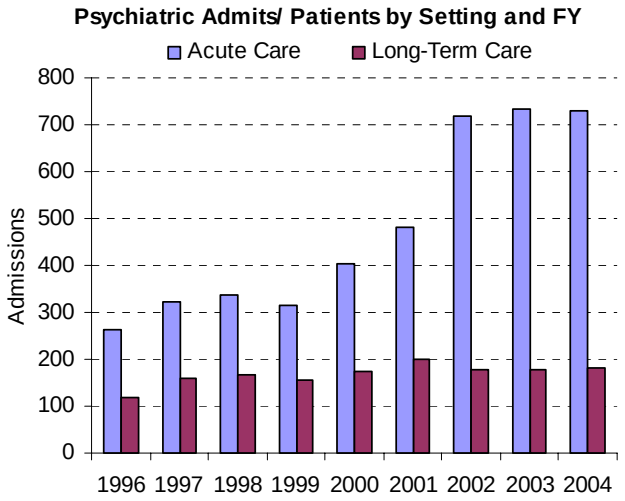
Background:

In early 2002 the Executive Director for the Division of Behavioral Healthcare, Department of Mental Health Retardation and Hospitals, Craig Stenning, requested that the Governor's Council on Behavioral Health study and make recommendations to his office concerning a dramatic and startling increase in the number of acute inpatient admissions to state-funded beds at Butler Hospital in Providence. The Council concurred, and a subcommittee was appointed, chaired jointly by Nicki Sahlin, Ph.D., Executive Director of NAMI Rhode Island, and Elizabeth Earls, Executive Director of the Rhode Island Council of Community Mental Health Organizations. The Division of Behavioral Healthcare provided staff support to the subcommittee, particularly in the area of data analysis.

Admission to these beds, funded solely by state general funds, is only through the Community Mental Health Center responsible for one of the eight catchment areas in the state. Neither community hospitals nor Butler Hospital itself can admit directly to these beds. The patients are indigent, uninsured persons, meeting criteria for inpatient level of care

The number of patients admitted to these beds had ranged from below 300 in FY1996 to just above 300 in FY1999.

Starting in FY2000, however, the number of admissions began a dramatic and startling climb: the number jumped to just over 400 in FY2000 , to just under 500 in FY2001, to 720 in FY 2002, to 750 in FY2003, leveling off to just under 750 admissions in FY2004.



The change in acute care admissions is particularly notable when compared to the stability in the long-term care setting, which has increased only slightly over the 9 years shown here.

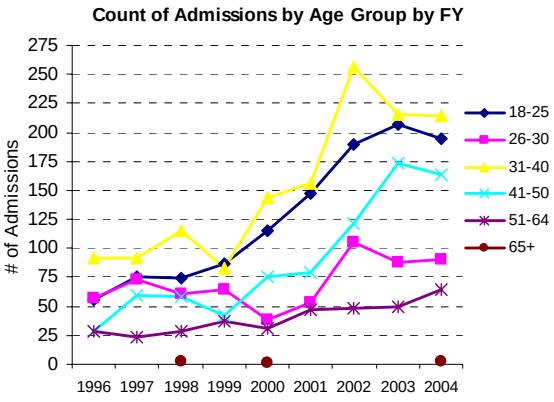
Various hypotheses were advanced as to why there was a 167% increase in acute inpatient admissions. There was considerable sentiment among clinicians (at the community mental health organizations, Butler Patient Assessment staff and Division of Behavioral Health staff) that there was a qualitative difference in the clinical phenotypes of patients being admitted to the Butler beds (state beds). Other than general agreement on this particular point, there was a wide divergence of opinion as to the characteristics of the population being admitted to the state beds.

Some clinicians advanced the plausible theory that more DSM IV© Axis II (Personality Disorders) patients were presenting. Others advanced the equally plausible theory that because of the gap between the child and adolescent mental health services and adult mental health services (the two systems do not align neatly in terms of how the priority populations are selected), many more young, uninsured adults were presenting. Still other clinicians felt that there were many more patients with substance abuse presenting, and that this group of patients was largely unknown to the public mental health system. A variant of this hypothesis was that because of liability concerns, and recent research showing a higher potential for suicide among individuals who were both mentally ill and abusing substances, community mental health organization clinicians were more likely to hospitalize patients presenting with both conditions than previously.

Data analysis indicated that there was a clear change in patient phenotype, with much greater incidence of substance abuse than in previous years, patients who were largely unknown to the mental health system, and substantial incidence of mood disorders. There was a large increase in the 18-25 year old and 31-40 year old cohorts, a lesser increase in the 41-50 year old cohort, and a small increase in the 26-30 year old cohort. Proportionally, the 18-25 year olds and 31-40 year olds had the largest increases.

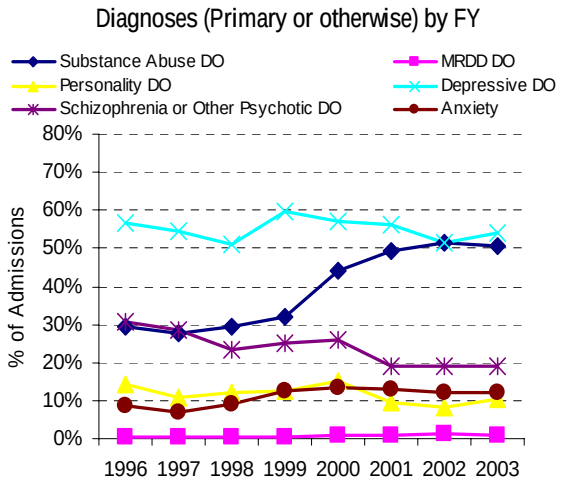
No amount of internal data mining or analysis could, by themselves, explain the substantial increase in admissions to the state beds.

Data Analysis walk-through



The first pass through the data, analyzing admissions by age group showed the largest increase in hospitalizations were adults aged 32-40, followed by the 18-25 year olds, 41-50 year olds, then the 26-30 year olds. There was a definite increase in the 51-64 year category, but the base rate of hospitalization for this cohort, as well as rate of increase in hospitalization, were the lowest of the five cohorts with reportable results (adults over the age of 65 did not have a statistically significant amount of hospitalizations under this program, since most adults over 65 qualify for Medicare coverage).

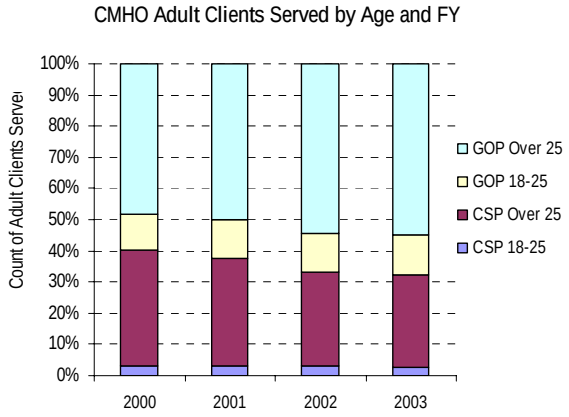
Examination of diagnostic criteria indicated that only substance disorders increased in the population admitted to the state beds over the period:



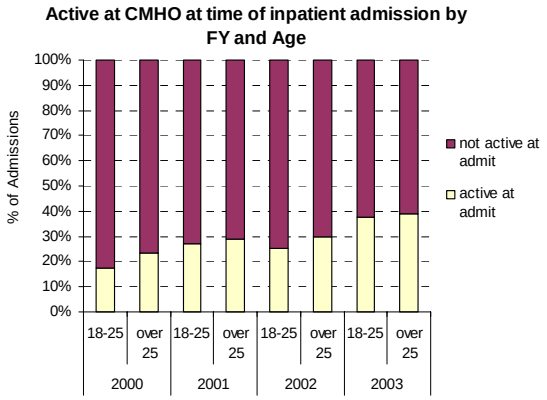
Analysis of age at time of admission

One possibility that was considered was that there was a general increase in younger clients seeking mental health services in general, and inevitably a proportion of those would require inpatient care.

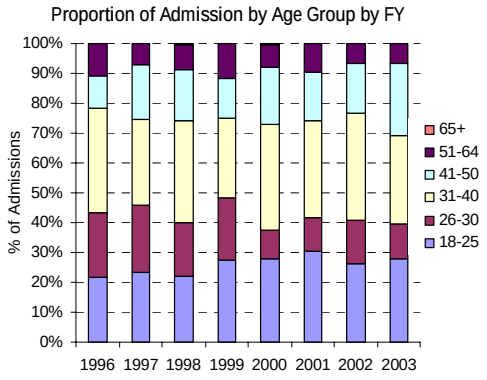
However, the increase in the proportion of 18-25 year olds is not evident in the clients served at the community mental health organizations (see below figure). There, the percentage of clients aged 18-25 who were served in either GOP or CSP programs has consistently held at approximately 14% of the overall provider clientele across the past three fiscal years for which data is available.



Nor was there significant variance across age groups in the proportion of people active at a community mental health organization at the time of hospital admission does. Younger people were somewhat less likely than older people to be active agency clients at the time of hospital admission in all years (see figure below), but probably not to the extent that it would explain the large increase in the use of acute care beds by adults aged 25 and under.



Next, looking at the *proportion* of all admissions, the proportion of group has remained fairly stable across the past 8 years, with a steady increases in the proportion of patients age 25 and under and smaller increases in patients age 41-50. The number of patients age 31-40 has shown the greatest volatility over the period, and remains the largest single cohort admitted in all years except 1999.



Other variables were examined, such as length of stay (LOS), rate of first-time admissions versus readmissions, whether patients were actively involved in treatment at a community mental health organization prior to hospitalization. There has been an increase in re-admissions over the, but again, not a dramatic increase.
Some increases in variables could conceivably explain part of the increase in acute hospital admissions. Even taking all such possible increases into account, no coherent explanation emerged of how a 167% increase in admissions occurred, nor could the magnitude of the increase be explained.

Clinical characteristics of patients using state "state beds"

What did emerge from the data analysis was a clearer clinical picture of patients being admitted to the state beds: more 18-25 and 31-40 year old patients, much greater incidence of substance abuse diagnosis (increased from 30% to 50% of diagnoses, see figure 3 above), mood disorders often involved (55%); patients largely unknown to the mental health system (in 2004, only 30% of patients admitted to state beds had any prior contact with the community mental health system). Admissions for psychotic disorders and personality disorders were down over the period, and anxiety disorders increased slightly.

Clearly, the answer as to what the major driver(s) of the increase in acute hospital admissions lay in factors that would previously have been considered "externalities" to the community mental health system.

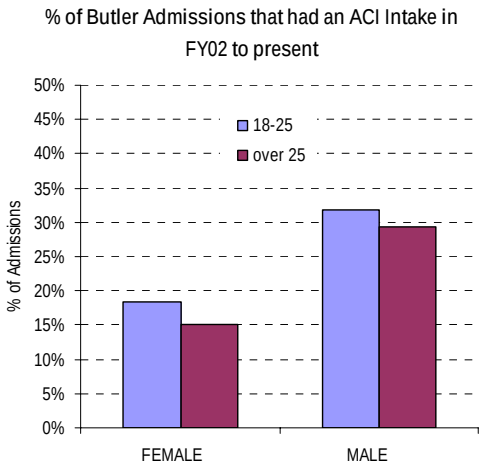
Externalities

Over the previous 5 years there has been increasing awareness nationally that persons with mental illnesses make up an appreciable fraction of jail and prison populations. This required a change in mindset, since the prevailing view had been that persons with mental illnesses were more often victims of crime than criminals. While this view is not inaccurate, it fails to take into account the difficulty that persons with behavioral disorders generally have with conforming to the behavioral norms of modern society. Overhasty de-institutionalization, with inadequate community resources have led to what is often termed "cross-institutionalization" of the mentally ill, with these persons moving more or less directly from state hospital to state prison or local or county jail.

Another driver in cross-institutionalization has been the dramatic increase in substance abuse over the last generation, and the recognition that co-occurring mental illness and substance abuse disorders are more often the rule rather than the exception. Treatment systems developed in parallel, as two separate treatment systems evolved, each with its own culture, values, norms and mythos, one for mental illness, the other for substance abuse. While it is impossible to accurately pinpoint the exact frequency of co-occurring disorders (COD), the best estimates (from NIMH, NIAAA and NIDA) range from 50% to 75% of persons diagnosed with mental illness have a co-occurring substance disorder. Despite this datum having become the accepted norm, treatment specifically tailored for persons with COD is still relatively uncommon. Payor systems, federal, state and private have yet to develop adequate reimbursement strategies, and the two treatment systems are in the beginning phase of the process of integrating.

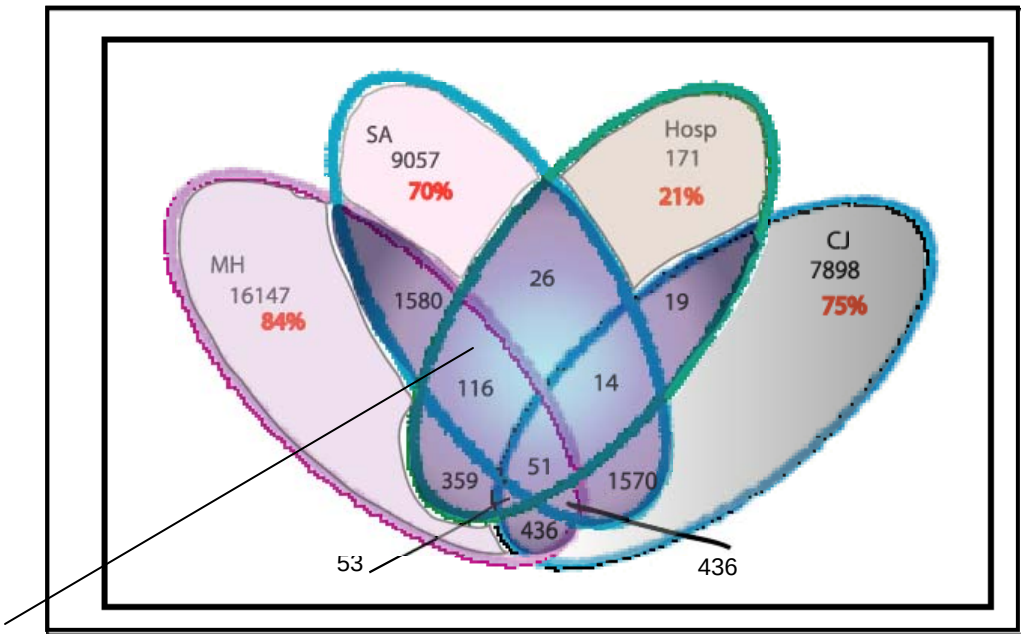
This is the background to the situation here in Rhode Island. While the state has been relatively successful in avoiding many of the pitfalls of an inadequate community mental health system, there are certainly many characteristics that it has in common with the national scene. Chief among those would be a high number of persons living with COD and significant numbers of people with mental illness and substance abuse disorders having interactions with the criminal justice system. Many of these individuals use the public mental health system, the public substance abuse treatment system, spend some time at the state prison, and also use the state beds at Butler Hospital.

The accompanying chart shows that patients using the state beds at Butler have substantial involvement with the criminal justice system: just over 30% of males age 18-25 and just under 30% of males over 25 have been intaked at the ACI in FY 2002 and 2003. The corresponding numbers for females were: 18% of female patients age 18-25 in the state beds and 15% of females over 25 had been intaked at the ACI.



Using the Venn diagram below, we can see that 43314 unique individuals received services in FY 2003 from either the mental health system (MH), the substance abuse system (SA), the state beds at Butler (HOSP) or at the Adult Correctional Institution (CJ), which serves Rhode both as prison and jail. Of the 43314, 7027, or 16%, received services from two or more service areas – "co-occurring services".

43314 unique persons served in FY 03



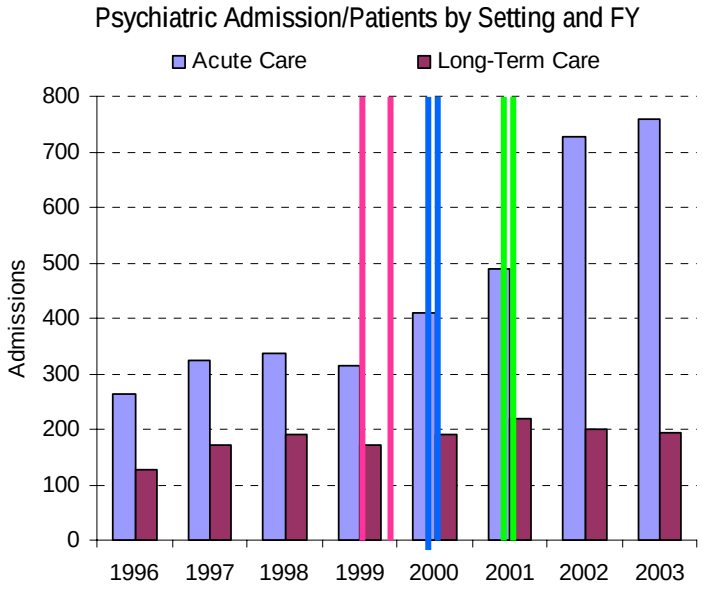
7027 overlapped service "areas" – were co-occurring

What was clearly of most interest to the subcommittee was the population that was using 3 or 4 service areas. There were a large number of people using only two service areas – 6154, but there were 51 individuals using all four service areas, and 823 using three. That is to say, there were 874 individuals who were extremely high users of services. It is possible using MHRH data and ACI data to drill down to the level of the individual and perform case analysis and examine system resource utilization.

Analyzing this data is down to the individual level is beyond the charge of this subcommittee, and would require a substantial number of resources not currently available to MHRH to complete.

It would seem reasonable for the Council to look into requesting funding to study this population, and determine cost effective interventions. This should reduce overall system expenditures, while improving care for seriously compromised individuals. Another deliverable of such a study should be to set up a system that would identify high users of service systems in real time, rather than waiting months to identify them, as is the current practice. While these months pass, many opportunities to intervene are missed.

Unfortunately, the forgoing analysis, while helpful, tells us nothing directly about what is driving increased use of state beds. Members of the subcommittee who had been involved in system advocacy for many years recalled that there were several events that occurred in 1999, completely out of MHRH's locus of operations that in the subcommittee's view, could very likely have played a significant role in increasing acute inpatient admissions to the state beds.



Displayed here is a copy of figure 1, from page 2 of this report. Overlayed on the graph are 6 lines, the first series of two in magenta, the second series in blue, and the third in green. The placement of each line on the X-axis (the year) corresponds to an event, well

documented at the time by articles from the Providence Journal, affecting the mental health system here in Rhode Island. The first two bars, in magenta, are the most significant in terms of impact. The first bar, in June, 1999, was the point when Blue Cross of Rhode Island, which had been hemorrhaging reserves for some time, due to extreme competitive pressures, cut back its reimbursements to mental health providers by nearly 20% (United Behavioral Health followed suit). Following this, HMO Harvard-Pilgrim ceased and closed all operations in Rhode Island effective December 31, 1999 (second magenta bar).

It is difficult to overstate the impact that these two events, and their causes have had on the topology of the mental health system here in Rhode Island – as well as the overall health care system. Blue Cross was in dire financial straits because Harvard-Pilgrim was operating so inefficiently that it failed to charge adequate premiums to meet statutory reserves, and to stay in business. United Health, the third major player in RI health care was not in good shape either, due to premium competition caused by Harvard's grossly under priced premiums, but it had a broader national economic base to fall back on.

The closure of Harvard-Pilgrim caused concerns about quality and quantity mental healthcare services, since Harvard-Pilgrim's staff model offered one of the best out-patient levels of care for persons with serious mental illness in the state.

Initially, many of the professionals at Harvard-Pilgrim went into practice in the area, as they were understandably loath to relocate. There were no immediate crises, which was testament to the resilience of the system at the time, but there were well-founded concerns that the crisis was only deferred, not averted. Butler Hospital's then state-wide outpatient network, and the community mental health organizations, and other groups stepped in to fill the gaps left by Harvard-Pilgrim's departure.

By June of 1990, Butler Hospital had begun to feel acute revenue pressure due to the Blue Cross (and United Healthcare) reimbursement cuts, essentially losing money on every outpatient visit. In response, Butler began to reduce the number of outpatient clinicians and visits, beginning an orderly process in which providers and patients moved out into independent practices. This is represented on the graph by the first blue bar, in early 2000; later in 2000, there was a second phase in Butler reducing outpatient capacity, followed in 2001 by The Providence Center closing a West Warwick substance abuse clinic, and a third major reduction in outpatient services at Butler late in 2001.

Butler is used as a proxy for the private sector outpatient system in this report, and also of the effect of outpatient cutbacks for two reasons: first, because the information on its cutbacks was announced publicly, and two, because the adverse financial pressure experienced in its statewide outpatient system was more visible than that experienced by individual practitioners. Butler had expanded its outpatient network, initially in cooperation with Blue Cross, in order to reduce inappropriate inpatient stays, as well as to offer a better continuum of care, similar to the public community mental health system in Rhode Island.

This plan, imaginative and innovative, fell apart because of the hammer blows experienced by the system in 1999, the rate reimbursement and the closing of Harvard-Pilgrim. These blows were triggered by Harvard-Pilgrim's pricing its product so low that it went out of business, and came close to taking Blue Cross with it, and was causing other insurers to look askance at staying in such an unprofitable environment.

By the time the dust lifted, after 2001, most of the specialty psychiatric programs, aside from several in the public mental health system, had been decimated. Eating disorders, specialty women's programs, especially DBT had been disbanded. Many providers from these programs continued to practice in Rhode Island, but fewer (if any) were accepting private insurance.

The hallmark of the new private mental health system is the inability of patients to access private psychiatrists and other providers in a timely way – if they are using insurance. If patients were prepared to pay "out-of-network", fee-for-service rates, and be reimbursed by their insurer, care was available immediately. If patients could not pay out-of-pocket (and were insured), they would have to wait to see a mental health practitioner. Waits of a month to six weeks are not unusual. If substance abuse is involved, many private providers will not schedule appointments. One of the sadder experiences was that of a Blue Cross employee, seeking an appointment for an ill relative, who called all the psychiatrists in the Blue Cross network, only to be told that there were no openings in any of the practices.

Somewhere between 40 to 50 per cent of psychiatrists in Rhode Island do not accept insurance, according some estimates. Many of those who do accept insurance are associated with hospitals and organizations like the community mental health organizations which do business with the insurers. Finding an outpatient practitioner who participates in a network is challenging.

The picture of the behavioral healthcare system in Rhode Island is this: the public system does a good job dealing with individuals with severe and persistent mental illness (SPMI), those who meet the definition of the priority population. The private system does a good job with individuals (and families) capable of paying private rates, and not relying on private insurance to reimburse the mental health provider. There two groups in the middle, one made up of individuals who must depend on insurance in order to receive treatment, and another one made up of the uninsured, whom nobody seems to want to take care of. It is this group that the subcommittee feels that is the source of most of the patients who use the state beds at Butler Hospital. It should be noted that the committee feel that this group has grown so large, in part, because of the shrinking of access to treatment in the private sector, while the public sector is also chronically underfunded. Since 1991, the private mental health sector has had no rate increases (until 2003 when there was a 2% increase) and a 19% cut in reimbursement in 1999. The public sector has received 2 increases in funding, neither large. The public sector has grown through the leveraging of state funds with federal dollars, but only by being focused on Medicaid-reimbursable services. Unfortunately, few of these individuals qualify for Medicaid.

There is also a visible phenomenon taking place, that of displacement of many of these individuals from the ranks of the insured to the uninsured, from the private sector, to the public sector. This is a result of years of deferred maintenance to our private mental health system. The mental health of many individuals deteriorates because they cannot access care. They then need the services of the public system, since they are no longer insured because of job loss and other vagaries experienced while one experiences untreated mental illness and substance abuse.

Any strategy to craft interventions with this group should be prioritized around those individuals who use the most services (hospital, criminal justice system, substance abuse and mental health). In discussions with clinical staff at Butler hospital regarding this patient population, it is clear that the issue of homelessness is also critical. It is not uncommon to have the only point of discharge be a homeless shelter. While this may seem cruel, and is certainly not an outcome anyone would regard as desirable, when a patient no longer meets inpatient criteria, he or she must be discharged. In a mental health system so starved for funding, and with bed supply running very tight, such discharges have to happen. The alternative is to have patients back up in hospital emergency departments, which is increasingly a problem, and is unacceptable, since there is no possibility of treatment in this milieu.

Recommendations of the subcommittee to the Governor's Council/ Items for action:

1. That the Council request the Executive Director of Behavioral Healthcare determine the feasibility and need for further study of the individuals using three and four "service areas" (see page 7 above), and costs of such as study. Since the resources for such a study are not in the Division budget at this time, the Council should consider forwarding any request for funding to the Governor.

2. It is obvious that the state general funds allocated for General Outpatient Services (GOP) are inadequate for the growing need for these services. The Division has targeted GOP funds to be prioritized for persons using the state beds at Butler. Even with this prioritization, there is simply insufficient funding in this critical area of operations. The Budget office is considering a cut to GOP funds; we must make it clear that only additional funding

3. It is clear from the discussion of the data that co-occurring disorders are a problem that appears to be getting worse, not better. While re-organizing the Substance Abuse Outpatient system may help alleviate bed usage to a degree, the sub-committee urges the Council to request that the Division seek additional funding to help improve treatment of co-occurring disorders.

4. The subcommittee recommends strongly to the Council that a letter, to Blue Cross and United Healthcare, requesting that increased [adequate] reimbursement for mental health and substance abuse providers be implemented as soon as possible. A minimum of 20%

should be considered. To not act in this instance, is to decide to allow the mental health system continue to deteriorate.

5. We applaud the efforts of the Division and the Department of Corrections for the close relations the two entities have forged, to assist persons with behavioral disorders caught up in the criminal justice system. The daily data share is only one aspect of that collaboration. We encourage both departments to continue the collaboration and expand it, seeking funding wherever possible.

6. The subcommittee has been impressed by the data gathering and analysis capabilities of the Division. We encourage the Division and its data unit to work with the Coalition for the Homeless and its HMIS (Homeless management information system) to see where these populations intersect, and see if there are innovative collaborations that can benefit this population.

Appendix

Summary of actions since beginning of subcommittee study process (not all resulting from subcommittee work, but having a bearing on the population defined in this report)

Actions:

- **Butler Contract: use of risk corridors to reduce cost of indigent hospitalization**
- **Direct State GOP Funds to prioritize Butler Bed Patients**
- **RFP Substance Abuse Contracts, emphasize intermediate intensity of care**
- **Daily data share between DBH and DOC, FHR Community Reentry Program**
- **2 Court Diversion Programs**
- **Public Defender's pre-trial diversion program**
- **Substantial DOC investment in Behavioral Health; continued improvement in inter-departmental coordination**

Results:

- **2 Court Diversion Programs**
- **Public Defender's pre-trial diversion program**
- **Substantial DOC investment in Behavioral Health; continued improvement in inter-departmental coordination**

Outlook:

We can expect external pressures to continue:

1. **Availability of mental health professionals, especially psychiatrists remains a concern, since reimbursements in Rhode Island are extremely low, by regional and national standards. (Rhode Island ranks 49th out of 50 states in physician reimbursement). Psychiatrists are reimbursed (by Blue Cross) at 80% of RBRVS, while all other physicians are reimbursed at 100%.**
2. **The national trend is for the number of uninsured to grow. Since our populations tend to have more uninsureds than average, we can expect continued pressure on public sector mental health.**

3. **Substance abuse trends show use occurring at earlier and earlier ages. The average age of "first use" for heroin addicts has gone down from age 22 to age 17 in less than 5 years.**

Challenges:

- **Funding pressures continue**
- **Lack of coordination between private insurers and public system (cost shift to public sector) – SHAPE 2**
- **Measure impact of Homelessness on BH system (DBH/HMIS coordination?)**